

PATIENT INFORMATION

When registering, please present proof of insurance, Medicare and/or Medicaid. Payment is expected at the time of service unless special arrangements are made.

PATIENT INFORMATION

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Marital Status: _____
Date of Birth: _____ Age: _____ Sex: M F
Driver's License Number: _____ State: _____
Social Security Number: _____
Student: Y N Referred by: _____

PATIENT'S EMPLOYER

Employer: _____
Occupation: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

PATIENT'S SPOUSE/GUARDIAN

Spouse/Guardian: _____
Relationship: _____ Phone: _____
City: _____ State: _____ Zip: _____
Employer: _____ Phone: _____

RESPONSIBLE PARTY (if other than patient)

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____ Phone: _____
Social Security Number: _____
Emergency Contact (not living with you): _____
City: _____ State: _____ Zip: _____
Phone: _____

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance. I authorize the release of any medical or other information necessary to process this claim. I also request payment of claims to be paid to Pulmonary Associates of Brandon.

Signature: _____ Date: _____

SMOKING: Do you smoke? _____ Have you ever? _____
How many total years? _____ How many packs per day? _____
Have you quit? _____ When? _____

ALCOHOLIC BEVERAGES: Do you drink? _____ How many drinks per day? _____
Beer? _____ Wine? _____ Liquor? _____

HOUSEHOLD PETS: Do you have pets at home? _____ Indoor or outdoor? _____
Please list them (dog, cat, bird, etc.): _____

HOBBIES: Please list your hobbies and recreational activities:

When was the last time you had the following test (approximate date or year):
TB Skin Test _____ EKG _____ Chest X-Ray _____ Breathing Test _____

MEDICATIONS (please list all medications, including vitamins, aspirin, birth control pills, Tylenol, etc.):

Current:

Name/Strength	Reason Taken	How Often	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Last Six Months:

Name/Strength	Reason Taken	How Often	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES: Are you allergic to medications? _____ What reaction do you have?
Medications: _____ Reaction: _____

Other Allergies (eggs, dust, animals, etc.): _____

Please check appropriate space if you have had any of these illnesses:

CHILDHOOD: Rheumatic Fever _____ Mumps _____ Asthma _____
Scarlet Fever _____ Measles _____ Other _____

ADULT:

Glaucoma	_____	Stroke or Paralysis	_____
High Blood Pressure	_____	Diabetes	_____
Stomach Ulcers	_____	Arthritis	_____
Hepatitis/Jaundice	_____	Gout	_____
Cirrhosis of Liver	_____	Thyroid Disease	_____
Colitis	_____	Anemia	_____
Diverticulitis	_____	Tuberculosis	_____
Gallstones	_____	Hay Fever	_____
Pancreatitis	_____	Pneumonia	_____
Kidney Stones	_____	Pleurisy	_____
Gonorrhea/Syphilis	_____	Bronchitis	_____
Depression	_____	Emphysema	_____
Nervous Breakdown	_____	Heart Disease	_____
Epilepsy/Seizures	_____	Cancer	_____

HOSPITALIZATIONS AND SURGERIES (please list all your hospitalizations and surgeries):

19 _____ Reason _____ Doctor/Hospital _____
19 _____ Reason _____ Doctor/Hospital _____
20 _____ Reason _____ Doctor/Hospital _____
20 _____ Reason _____ Doctor/Hospital _____
20 _____ Reason _____ Doctor/Hospital _____

FAMILY HISTORY: Father Living _____ Age _____ Deceased _____ Age _____
Illnesses _____ Cause of Death _____
Mother Living _____ Age _____ Deceased _____ Age _____
Illnesses _____ Cause of Death _____

List the name, living, age, and illnesses:

BROTHERS:

SISTERS:

Please check if any of your blood relatives have had any of the following:

Asthma	_____	High Blood Pressure	_____	Epilepsy	_____
Emphysema	_____	Heart Disease	_____	Cancer	_____
Bronchitis	_____	Stroke	_____	Hay Fever	_____
Tuberculosis	_____	Arthritis	_____	Anemia	_____
Diabetes	_____	Gout	_____	Other:	_____

REVIEW OF SYSTEMS (If you have had any of these symptoms within the last 6 months, please put a check by them. If you are unsure, please put a ?):

Weight _____ Have you gained or lost over 10 pounds in the past year? _____

SKIN

- _____ Chronic skin irritation
- _____ Lump or growth
- _____ Change in skin color
- _____ Skin cancers

EYES

- _____ Glasses
- _____ Change in vision
- _____ Pain in eyes
- _____ See halo around lights

EARS

- _____ Trouble hearing
- _____ Earaches
- _____ Discharge from ears
- _____ Buzzing or ringing in ears

NOSE AND THROAT

- _____ Frequent sneezing
- _____ Nose continually stuffy or runny
- _____ Frequent sore throats
- _____ Hoarseness

BREAST

- _____ Lump
- _____ Discharge
- _____ Pain

HEART AND LUNG

- _____ Chest pain with activity
- _____ Other chest pain
- _____ Shortness of breath
- _____ Sleep with more than one pillow to help you breathe
- _____ Blood in sputum
- _____ Wheezing
- _____ Unusual heartbeat
- _____ Heart attack
- _____ Swollen ankles

GENERAL

- _____ Loud snoring
- _____ Unusual fatigue
- _____ Unusual weakness
- _____ Swollen lymph glands
- _____ Fever in past month
- _____ Night sweats

ENDOCRINE

- _____ Frequent urination
- _____ Unusual thirst

GENITOURINARY

- _____ Painful urination
- _____ Frequent urination
- _____ Blood in urine
- _____ Discharge from vagina or penis
- _____ Blood or pus in urine
- _____ Difficulty starting urinating

MUSCULOSKELETAL

- _____ Painful joints
- _____ Sore muscles
- _____ Back pain
- _____ Unusual weakness

NEUROPSYCHIATRIC

- _____ Frequent or severe headaches
- _____ Dizziness or fainting
- _____ Depressed
- _____ Convulsions/epilepsy

LUNGS

Shortness of breath:

- _____ at rest
- _____ walking uphill or upstairs
- _____ walking level with others your own age
- _____ walking level at your own pace
- _____ washing or dressing

How far can you walk without stopping? _____

Do you exercise regularly? _____

What type? _____

STOMACH AND LIVER

- _____ Frequent heartburn/indigestion
- _____ Frequent nausea or vomiting
- _____ Stomach pain
- _____ Constipation
- _____ Bleeding ulcers
- _____ Hemorrhoids
- _____ Blood in bowel movements
- _____ Loss of appetite
- _____ Vomiting blood
- _____ Black bowel movements

REVIEW OF SYSTEMS (If you have had any of these symptoms, please put a check by them. If you are unsure, please put a ?):

COUGH:

Do you usually cough first thing in the morning? _____
Do you usually cough after going to bed at night? _____
Do you cough every day for at least three months out of the year? _____
How many years have you had this cough? _____
Do you bring up phlegm or sputum with your cough? _____ What color? _____
How much phlegm do you usually bring up in a 24-hour period? _____ (tsp, tbs, cup)
Have you ever coughed up blood? _____ If yes, when? _____
Did you see a doctor about this? _____ Did you get an x-ray? _____

WHEEZING:

Have you ever noticed whistling or wheezing in your chest? _____
How frequently (circle one): Daily Weekly Monthly After Colds Only
Is your wheezing more common during any particular season? _____
Which season? _____
Is your wheezing related to any of the following? (circle all that apply)
House Dust Animals Deep Breaths Cough
Meals Skipping Meals Moving Arms
How many years have you had this chest pain? _____

ASTHMA:

Have you ever had asthma? _____
Have you ever gone to the emergency room for your asthma? _____
How often do you have an attack? _____
Do you have polyps in your nose? _____

SINUSES:

Do you frequently have postnasal drip? _____
Do you frequently have tenderness over your cheekbones? _____
Have you ever had surgery on your sinuses? _____
Have you ever had the following? (check all that apply)
_____ Frequently waking at night with an acid or sour taste in your mouth
_____ Waking up with a sore throat in the morning
_____ A burning chest pain that goes into your throat, especially when you lie down

PULMONARY ASSOCIATES OF BRANDON

Florida Sleep Disorder Center

Richard S. Powell, M.D. ^{†*}

Daniel G. Lorch, Jr., M.D. ^{†*}

Thomas P. Hooker, D.O. ^{†*}



Arthur E. Graves, M.D. [†]

Suketu K. Shah, M.D. ^{†*}

Niraj C. Mahajan, M.D. [†]

Diplomate: American Board of Pulmonary Disease & Critical Care⁺; Sleep Medicine^{}
Accredited Sleep Disorder Center*

ASSIGNMENT OF BENEFITS

In consideration of Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon services rendered or to be rendered, I assign and transfer any interest in any cause of action to Florida Sleep Disorder Center at Brandon any benefits payable to or for my benefit under my medical insurance policy for payment of services rendered. I agree to fulfill all policy provisions such insurance companies may require for payment. I authorize Florida Sleep Disorder Center at Brandon to initiate a complaint to the insurance commissioner for any reason on my behalf.

I authorize Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon to release any medical information pertaining to my diagnosis and to/or treatment, including laboratory test results, medical history, treatment progress, or any other such related information to: (1) representatives of local, state, or federal agencies in accordance with law; (2) my insurance company or its designated representative; and/or (3) any person(s) or entities financially responsible for my care and treatment. I understand this information may be required to be released in order to obtain payment for my medical expenses incurred at Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon.

I understand that if I receive payment from my insurance company for services rendered by Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon, I am obligated to promptly reimburse Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon for the full amount that I receive. If collection action must be taken to reimburse this facility for misappropriated funds owed Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon, I will be held liable for all charges billed to my insurance company as well as any legal fees incurred.

I, THE UNDERSIGNED, PATIENT OR PATIENT REPRESENTATIVE, HAVE READ AND UNDERSTAND THIS INFORMATION.

Patient/Representative

Date

Witness

Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

Pulmonary Associates of Brandon
910 Oakfield Dr. Suite 102
Brandon, FL 33511
(813) 681-4413

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy at our offices.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing signed by you. However, such a revocation shall not affect any disclosures already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

I, _____, acknowledge receipt of the Notice of Privacy Practices from Pulmonary Associates of Brandon.

Signature: _____ Date: __/__/__

Witness Signature: _____ Date: __/__/__

PRIVACY PRACTICES ACKNOWLEDGEMENT

Pulmonary Associates of Brandon
910 Oakfield Dr. Suite 102
Brandon, FL 33511
(813) 681-4413

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

II. Please list the family members or significant others, if any, whom we may inform about our medical condition ONLY IN AN EMERGENCY:

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

IV. Please indicate if you want all correspondence from our office to be sent sealed in an envelope marked "CONFIDENTIAL".

_____ YES _____ NO

V. Please print the telephone number where you want to receive all calls about your appointments, lab and x-ray results, or other health care information, if other than your home phone number.

VI. Can confidential messages (i.e.: appointment reminders) be left on your telephone answering machine or voicemail?

_____ YES _____ NO

Patient Name: _____

Patient/Guardian Signature: _____ Date: ____/____/____

Last Update: June 30, 2008

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Beginning November 15, 2007

We will ask for payment at the time of
service for co-pays, deductibles, and
estimated amounts of personal payment
due after insurance.